Vermont Department of Disabilities, Aging and Independent Living Choices for Care - Enhanced Residential Care Service Plan

Participant Name:		Soc. Sec. #					
Participant Name:(Please Print)			☐ Initial Assessment ☐ Reassessment ☐ Change				
Address:							· ·
	Street)	Start Da	Start Date:				
(Town) (Zip Code)			Date of Birth:				
Phone Number:			Diagnosis:				
DAIL UR			ICD-9 C	ODE			
Service		Provider (Write in provider name)	Hours of Service		Rates		Cost/Month
⊠Case Management		AAA: Home Health:	Up to: 48hrs/yr		\$69.28hr		\$277.12
Enhanced Residential Care	ER	C Provider Name:	24 hrs/day 7 days/wk	TIER 1 \$50.10/day RCH \$55.43/day ALR \$1508.01/month RCH \$1668.44/month ALR			
			24 hrs/day 7 days/wk	TIER 2 \$57.04/day RCH \$62.36/day ALR \$1716.90/month RCH \$1877.04/month ALR			
			24 hrs/day 7 days/wk	TIER 3 \$63.96/day RCH \$69.30/day ALR \$1925.20/month RCH \$2085.93/month ALR			
			•	Tota	al Monthly Cos	<i>t:</i>	
	d by Cl	noices for Care – Formal Serv				1 -	
Services		Service Provider	Funding Sou		Frequency	Cost per Month	
□ ACCS □ Room & Board			MEDICAID SELF)	DAILY MONTHLY		
Hospice			SELF	SELF INIONITE!			
Skilled Services							
		Disabilities, Aging and Inc	dependent Livin	g Aut	horization/Offici	ial L	Jse Only
Services are auti (A full reasses	norize ss <i>men</i>	d effective: Start Date: t must be completed prior	to the end date	throu in or	gh End Date: der for ERC serv	vice	s to continue)
DAIL Authorized S	Signati	ıre			 Date		

CONSENT TO PLAN OF CARE

l,	, have been fully informed of the proposed the terms as described in this Service Plan . I consent to this plan and accept it as					
SERVICE PLAN and understand the terms as des an alternative to the Home-Based or Nursing Hom		ice Plan. I consent to this plan and accept it a				
>		Date:				
Signature of applicant/participant or legal represent	ative					
>		Date:				
ERC Provider Signature						
Case Manager Name/Print	Agency:	Phone #:				
Case Manager Name/Print						
▶Case Manager Signature		Date:				
NOTE: All Plans <u>must</u> be <u>signed</u> by applicant/partic Case Manager, and ERC Pro	cipant or legal repre ovider in order for s	esentative (Power of Attorney or legal guardian), services to be authorized.				
<u>Service Plan Changes</u> : Complete a new Service supporting information.)		<u>:</u>				

Important Information

Appeal Rights: See attached letter if services were reduced or denied by DAIL.

Changes: The individual or legal representative must report all changes in status to the case manager.

<u>Patient Share</u>: Refer to the Department for Children and Families (DCF) Notice of Decision for patient share amount (if any) and for the provider that the patient share is to be paid each month.

<u>Provider Billing:</u> Providers must retain a copy of the current <u>approved</u> Service Plan as authorization to bill for services. Providers may <u>only</u> bill for services provided within the limits indicated on the Service Plan.

Reassessments: Annual reassessments will start on the date after the previous Service Plan ends.

<u>Service Plan Changes</u>: Approved Service Plan changes will start no earlier than the date the Service Plan is received at the DAIL regional office.

***Level of Care Variances for ERC: A request for a variance from section 5.1.a of the VT RCH Licensing Regulations to retain or admit a resident whose needs exceed that for which the home is licensed to provide must be made to the VT Division of Licensing and Protection. This must be done for all residents being admitted or retained who meet nursing home level of care to receive ERC services. See page 7 section III. Variances in the VT RCH Licensing Regulations for details of how to make the request. http://www.dlp.vermont.gov/